

CLAIMANT'S NAME			SSN OR EMPLOYEE NUMBER*			DEPARTMENT		
Stephen W. Mayberg			461-500-1641-001			Mental Health		
POSITION		CBID	DIVISION OF BUREAU				INDEX NUMBER	
Director		E99	Director's Office				461-500	
RESIDENCE ADDRESS*			HEADQUARTERS ADDRESS				TELEPHONE NUMBER	
on file			1600 Ninth Street				654-2309	
CITY		STATE	ZIP CODE		CITY		STATE	ZIP CODE
					Sacramento		CA	95814

[illegible]

(Less Direct Pay) Reimbursement Request:

169.65

(11) PURPOSE OF TRIP, REMARKS, AND DETAILS (Attach receipts/vouchers when required)

11/18- Director to preside at Atascadero State Hospital Governing Body meeting.

(12) Normal Work Hours	8:00 a.m. to 5:00 p.m.
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(13) Pvt Vehicle License #

On file

(14) Mileage Rate Claimed

#	###	0.55
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ONLY

Paid by Revolving Check Number	
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* Direct pay

I HEREBY CERTIFY that the above is a true statement of the travel expenses incurred by me in accordance with existing agreements and Department of Personnel Administration regulations, in the service of the State of California and that all items shown were for the official business of the State of California, and if a privately-owned vehicle was used, I have met the requirements as prescribed by S.A.M. Sections 0751, 0752, 0753, and 0754 pertaining to vehicle safety and seat belt usage.

CLAIMANT'S SIGNATURE ▶	DATE	(16) SIGNATURE OF OFFICER APPROVING TRAVEL AND PAYMENT ▶	DATE
(17) SIGNATURE AND TITLE OF AUTHORITY FOR SPECIAL EXPENSES ▶			DATE